## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  #UBBARD HILL ESTATES INC  #URBARD HILL E	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
HUBBARD HILL ESTATES INC    DATE   SUMMARY STATEMENT OF DEFICIENCIES   ELKHART, IN 46517			155754	155754 B. WING				R-C <b>03/15/2011</b>
PREFIX TAG					STREET ADDRESS, CITY, STATE, ZIP CODE 28070 COUNTY ROAD 24			
This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure survey completed on 1/28/11. This visit included the PSR to the Investigation of Complaint IN00085421 completed on 1/28/11.  This visit was in conjunction with the Investigation of Complaint IN00086434.  Complaint IN00086434.  Complaint IN00085421- corrected  Survey dates: March 14 and 15, 2011  Facility number: 001131 Provider number: 155754 AIM number: 200823940  Survey team: Mavis Stob, RN TC Carol Miller, RN  Census bed type: SNF: 43 SNF/NF: 10 Total: 53  Census Payor type: Medicare: 19 Medicarid: 5 Other: 29 Total: 53  Sample: 8  Hubbard Hill Estates Inc was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		compliance with 42 C 410 IAC 16.2 in regar Recertification and Si	FR Part 483, Subpart B and rd to the PSR to the tate Licensure survey and					

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155754	B. WIN	3		R-	-C <b>5/2011</b>	
NAME OF PROVIDER OR SUPPLIER HUBBARD HILL ESTATES INC				28	EET ADDRESS, CITY, STATE, ZIP CODE 1070 COUNTY ROAD 24 LKHART, IN 46517		3/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 000}	Continued From page the PSR to the Invest IN00085421.  Quality review comple Bev Faulkner, RN		{F 0	00}				